Original Article

A Brief Case Series On The Clinical Psychologist's RoleIn Inpatient Pain Management

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Abstract

According to recent studies, between 25% and 33% of all hospitalizedpatients endure intolerable pain. Additionally, studies show that this raises costs, lengthens hospital stays, and lowers patient satisfactionlevels. Adequate pain management may be hampered by hospitals' efforts to discharge patients earlier. As a result, Chelsea and Westminster Hospital's pain service has adjusted to this evolving careparadigm. A growing amount of research indicates that psychologicalaspects play a significant role in how patients experience both acute and chronic pain.Therefore, it makes sense to recommend that inpatient pain management involve a clinical psychologist. This brief study examines three instances that demonstrate how adding a clinical psychologist to the inpatient pain team could enhance patient care. The active role of the psychologist in diagnosing and treating common conditions like anxiety and fear, as well as other psychiatric comorbidities, is especially demonstrated by two cases. Behavioral, cognitive behavioral, and dialectical behavioral therapeutic techniqueswere combined with brief counseling to create an eclectic approach that was adapted from chronic pain.The significance of nurse-patient interactions and the impact of the quality of nurse-patient relationshipson patient outcomes are best illustrated by the third case. In this case,the psychologist assisted in improving communication and resolving a challenging and possibly dangerous circumstance. The advantages ofhaving a clinical psychologist involved in inpatient pain management are covered in this brief case series, which highlights the need for innovative inpatient pain services initiatives. Future studies are necessary to validate this strategy, though.

Keywords: Clinical Psychologist's, Pain Management, Inpatient.

Introduction

Comorbidities and psychological disorders are often linked to pain. Forexample, a recent analysis of a database of over 100,000 patients withchronic low back pain in the United States showed that 13% of patientshad depression, 8% had anxiety, and 10% had sleep disorders. One Additionally, a recent European study on neuropathic pain found that 35% of these patients had depression and 42% had anxiety. 2.Patients with chronic pain also frequently experience anger (37%) andborderline personality disorder (BPD), which affects 30% of them (Gore, 2012).

Services must contend with rising demands and diminishing resourcesin the current economic environment, which places restrictions on health care budgets. Many patients are therefore being directed to "fast track" or "enhanced recovery" pathways, which were created to facilitate early discharge following standard procedures. However, effective pain management is necessary for all patients in order to support mobilization, rehabilitation, and timely discharge. On the otherhand, epidemiological research shows that between 25% and 35% ofhospitalized patients experience moderate to severe pain at any giventime, and that many patients are being released from the hospital with intolerably high pain levels (Langley , 2013).

Physical therapy and multimodal medication treatments are currently part of the standard inpatient pain management regimens. Clinical psychologists are currently primarily involved in treating psychologicaldisorders that result from burns or intensive care unit treatment. However, they are not frequently included in hospitalized patients' pain management plans. This is a startling finding because recent studies show that some mental health issues are linked to increased chancesof experiencing severe, acute, and ongoing postoperative pain, whichis not only uncomfortable for

patients but also has significant financialramifications (Fishbain, 2011).

Different behavioral phenotypes are the result of a patient's unique biopsychosocial model of illness and suffering as well as any pre- existing risk factors, such as those mentioned above.Better patient well-being is encouraged when these phenotypes are permitted to manifest externally and are viewed sympathetically by nursing staff.Conflict, on the other hand, emerges when phenotypes do not align with the biopsychosocial models of healthcare professionals, causing discomfort and discord for both patients and healthcare providers (Sansone, 2012).

For the first time, examples are provided in this article to bolster the aforementioned idea and show how a clinical psychologist can help patients in a large hospital with their pain.

Inpatient pain services :

The management of complex patients is increasingly involving inpatientpain services.To provide patients with the highest caliber of care, thesechanging demands necessitate both the creation of new resources anda significant restructuring of existing services. Clinical psychologists arenot yet frequently involved in the treatment of inpatients, despite mounting evidence that psychological factors are fundamental to patients' experiences of pain. The results of this small case series offerpreliminary evidence that questions the status quo and recommends that all inpatients should have access to psychological interventions ina manner akin to that which is currently common in outpatient pain management (Ip HY, 2009).

The purposeof a clinical psychologist's involvement ininpatient pain management :

Clinical psychologists can help hospitalized patients manage their painin a number of ways, including: enhancing patient satisfaction and quality of care; increasing motivation for and adherence to treatments;facilitating timely discharge and shortening hospital stays; and assistingpatients in getting the right care after discharge to avoid avoidable readmissions.

Interventions in psychology for inpatients:

Additionally, each patient had psychological comorbidities that significantly affected how they experienced pain and recovered from it. Low mood and particularly BPD were likely pre-existing conditions,while anger, anxiety, and fear were likely reactions to the patients' hospital stay. Each individual clinical condition may have benefited from the psychological interventions used here. The quick relief of patients' pain and their quick release from the hospital following the start of treatment lend credence to this idea. The encouraging follow-up comments we got further imply that this strategy is effective and well-liked by patients (Khan RS, 2011).

Hospital employees and pain psychology:

Hospitals in the UK have a complex biopsychosocial environment because of the diversity of their staff and patients. Every team member has a significant impact on the patient's outcome. Not all of these factors, though, may be advantageous, and staff attitudes and actions can occasionally have a detrimental effect on patients' pain experiences. Results may also be significantly impactedby patients' preexisting attitudes and behaviors. A clinical psychologist's involvement in a multidisciplinary pain management service offers a special chance to address psychosocial concerns thatmight hinder healing and discharge (Pavlin , 2005; Antrobus, 2011).

A case where staff attitudes and a breakdown in communication hadgreatly contributed to the patient's pain and distress served as an example of the necessity of actively engaging hospital staff.

Good nurse-patient relationships and efficient nurse-patientinteractions are seen by nurses as important pillars of their work. However, nurse-patient interactions are frequently minimized, even forpatients who are typically considered "unproblematic." The causes ofthis are numerous and covered in detail elsewhere. On the other hand,people frequently view patients who are in pain negatively as difficult to work with. As a result, nurses may avoid interaction, which could expose them to less-than-ideal care (Kehlet , 2007; Russell, 2012).

Recommendations:

It makes sense to include clinical psychologists in a multidisciplinary pain service for inpatients since they are already involved with outpatient pain services. This development reflects comparable advancements in outpatient pain clinics and is a reaction to the growingnumber of inpatients with complex pain issues.

This study had certain limitations even though it offers preliminary evidence in favor of this strategy. One could criticize, for example, the small number of cases that were presented, the seemingly random selection of patients, and the descriptive character of the outcome measures used. To "inform professional practice," a small multiple-casestudy design was selected because the addition of a clinical psychologist represents a significant change from current practice.

Lastly, to guarantee the clinical effectiveness and cost-effectiveness ofinterventions, precise and measurable outcome parameters must be established and rigorously assessed. For patients, these could includethe number of hospital readmissions related to pain, early mobilization,analgesic use, length of hospital stay, functional status, return to work, quality of life, depression and anxiety scores, and satisfaction with care.For physicians and nurses, it could involve stress levels, sick leave taken, or job satisfaction.

Conclusion:

It is commonly known that psychological comorbidities significantly affect how pain is managed. To help hospitalized patients manage theirconditions, there is currently no standard access to psychologicalservices. This implies that patients may need longer hospital stays andmore frequent pharmacological treatments, which could have been avoided with psychological interventions.

Restructuring inpatient pain services to create truly integratedmultidisciplinary pain management services may seem like animpossible task given the current economic climate of rising service demand and shrinking budgets. Nonetheless, this small case series shows that regular clinical psychologist involvement in hospitalized patients' pain management may improve clinical outcomes. Early mobilization, prompt hospital discharge, and decreased analgesic consumption are probably made possible by treating psychological comorbidities associated with pain. Therefore, psychologists may proveto be cost-effective as well as able to improve inpatients' quality of life and overall clinical outcomes by reducing length of stay and preventingneedless readmissions.

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